

Methods: All Emergency General Surgery cases operated upon between 01/08/2013 and 03/10/2013 were categorised as Immediate, Urgent or Expedited, and the time taken to get them to theatre was compared with the target times of 15-minutes, 24-hours and 72-hours respectively.

Results: There were 290 patients: all 4 "Immediate" cases were in theatre within 15-minutes; 92% of "Urgent" cases were operated on within 24-hours, 7% within 36-hours and the remaining 1% within 48-hours; and 100% of "Expedited" cases were done within 72-hours.

Conclusions: Only 8% of Urgent cases were delayed, but delays can prejudice length of stay and clinical outcomes. The diagnoses in the "Urgent" category were varied, so further sub-classification is needed to allow more meaningful analysis of this retrospective data to inform a prospective audit.

0582: BANDAGE: THE FREE, PAPERLESS, OPEN SOURCE, INTEGRATED PATIENT DATA MANAGEMENT SYSTEM

Angus Joyce^{*,1}, Sarah Aldugman¹, Thomas Bottomley¹, Natasha Castellino¹, Pavlos Christodoulo¹, Dominik Dotzauer³, Mohammed Kamal², Farhana Kapasi⁵, Omid Sadeghi-Alavijeh¹, Jane Sanders², Adam Sawyer⁴, Abeda Sultana¹, Ismail Vokshi¹. ¹Basildon Hospital, Essex, UK; ²SEPT, Essex, UK; ³University of Hamburg, Hamburg, Germany; ⁴Royal Free Hospital, London, UK; ⁵Norfolk and Norwich University Hospital, Norfolk, UK.

Introduction: Paper records systems are time consuming, expensive, and require significant infrastructure, making them impractical when dealing with large numbers of patients. We set out to design a paperless patient management system that could be deployed easily in a hospital or disaster setting; one that could be used and modified freely by anyone, and would significantly reduce healthcare costs whilst improving safety.

Methods: Our interdisciplinary team included experience of paper-based and paperless patient management systems internationally. We identified critical elements that should be present in a patient record system, reviewed common problems that were encountered, and examined technologies that could be modified to streamline data entry and access.

Results: We designed Bandage to address these problems and allow end-user customizability through the use of plug-ins, which add new features to the basic program architecture. We intend to crowd source Bandage's development as a free Linux platform, which could run on any computer, tablet or smartphone, and will incorporate robust PGP encryption to ensure patient confidentiality.

Conclusions: Duplication of effort and loss of information would be eliminated by integrating the clerking, drug chart, notes, and discharge summary. By reducing workload, more time becomes available for patient contact, improving care and patient satisfaction.

0698: WORKING TOWARDS SAFER POST-OPERATIVE CARE OF PATIENTS FOLLOWING UPPER AND LOWER LIMB TRAUMA: IT SOLUTIONS FOR OPERATIVE DOCUMENTATION CAN IMPROVE THE QUALITY OF MULTI-DISCIPLINARY COMMUNICATION

Rebecca Nicholas^{*,3}, Rosalind Brock⁴, Ruth Bennett², John McMaster¹. ¹Oxford Radcliffe Hospitals NHS Trust, Oxford, UK; ²Oxford University Medical School, Oxford, UK; ³London School of Surgery, London, UK; ⁴Royal Berkshire Hospital, Reading, UK.

Introduction: We evaluated the quality of operative documentation against the needs of the multidisciplinary team (MDT) and recognised professional standards. We engaged the MDT and used IT systems to drive improvement in this crucial element of safe patient care.

Method: Interviews were conducted with nurses, doctors, physiotherapists, occupational therapists and ward clerks to establish what information was needed from operative notes to deliver safe post-operative care. Together with the RCS (Eng) Guidelines, these standards formed the basis of evaluation. We analysed operation notes of 42 consecutive procedures for upper and lower limb trauma and presented the results locally. We then used the Bluespiers IT system to create an electronic proforma for operative documentation, which was adopted across the trauma service. Re-audit was performed the following year to complete the cycle.

Results: At initial audit 58% of operation notes were electronic, increasing to 98% at re-audit. There was dramatic improvement in the inclusion of post-operative instructions including weight-bearing status (26% to 96%); splint instructions (14% to 71%) and follow-up (55% to 74%).

Conclusions: IT systems can be used to drive dramatic improvement in the quality of operative documentation, facilitating effective multidisciplinary communication, accurate handover and the delivery of safer patient care.

0847: AN AUDIT OF AUDIT PERFORMANCE

C. Jukes^{*}, E.J.C. Dawe, G. Hill. *Frimley Park Hospital NHS Foundation Trust, Frimley, Surrey, UK.*

Introduction: Only 17-29% of audits performed by orthopaedic departments complete the audit cycle, the implications being that trainees spend much time and effort on ineffective projects that don't impact on service. We aim to determine how many orthopaedic audits at our institution complete the cycle and meet best practice criteria.

Methods: Retrospective analysis of project reports and presentation slides. NICE definition for clinical audit was used as a standard, and Healthcare Quality Improvement Partnership (HQIP) Criteria for Best Audit Practice were used to assess quality.

Results: Between July 2011 and March 2013, 32 projects were identified with only 17(53%) considered audits by NICE definition. The remainder were research projects and were excluded. Of the 17 audits: 12(71%) used clear standards/guidelines; 15(88%) attempted any recommendations for improvement; 8(47%) completed the audit cycle with 7(41%) demonstrating improvements in service. Only 5(29%) fulfilled HQIP best practice criteria.

Conclusions: Disappointingly few audits closed the loop, however nearly all that did demonstrated improvements in service, highlighting the effectiveness of well executed audit. By adapting our audit practices to promote audit completion, trainees can benefit by having participated in effective audit that is more likely to lead to improvements in patient service.

0852: EFFECTIVENESS OF A DAY CASE ABSCESS PATHWAY

Arslan Pannu^{*}, Kim Bailey, Giovanni Diana, Natalie Hirst, Karen Maude. *Scarborough General Hospital, Scarborough, UK.*

Introduction: To assess the effectiveness of a newly introduced 'Day case Abscess Pathway' (DCAP). This was created following an audit of patient flow and length of stay (LOS) when admitted to the main site hospital with an abscess requiring surgery. Strict criteria were established to identify patients suitable for treatment in a peripheral day surgery unit.

Methods: Prospective re-audit of patients admitted with an abscess over 6 months (April - Oct 2013). Data collected included demographics, abscess type, arrival time, time to ward, time to theatre, time to discharge and overall LOS.

Results: 56 patients with abscesses were admitted; 17 were suitable for day case surgery, 17 were operated during a weekend, 22 did not fulfil day case criteria. Of the 17 day surgery patients 9 were female. Median time to theatre was reduced in DCAP group compared to pre-pathway group (PPG) (5h 28 vs. 9h 3). Delay in median time to discharge was shorter in DCAP group versus PPG (2h 55 vs. 14h 15) and overall LOS reduced to 8h 19 in DCAP group versus PPG 24h 30.

Conclusions: The DCAP delivers an excellent patient centred service. Its introduction has saved bed days, shortened time to theatre and reduced LOS.

0866: HERNIA REFERRAL PATHWAY – STREAMLINING PATIENT REFERRAL PATHWAY TO DELIVER A COST EFFECTIVE, EFFICIENT PATIENT CENTRED CARE

Philip Varghese, Parminderjit Jayia, William Fusi-Rubiano, Frank Curran, Mangta Manu. *The Royal Wolverhampton Hospital NHS Trust, Wolverhampton, UK.*

Introduction: Evaluation of groin hernia referral pathway and streamlining patient referral by identifying factors influencing suitability for day case hernia repair.

Methods: A retrospective audit of groin hernia repair undertaken over 12 months period (100 patients) was evaluated for suitability under the proposed new pathway incorporating a 19 category Modified Charlson comorbidity score (MC).

Results: 93% of patients had groin hernia repaired as day case procedure. The majority were male (31-98 yrs), 94% with unilateral hernia. The duration of hernia, primary or recurrent hernia did not influence day case rates or overall outcome. Most hernia repairs are without complication.

37% of the patients had hypertension, which if well controlled did not affect the suitability of patients for streamlined direct referral and day case surgery. 7% of patients required overnight admission following the procedure which was unpredictable. An initial consultant led clinic appointment did not affect the overall outcome. Patient with MC score ≤ 3 are suitable for the streamlined assessment pathway.

Conclusions: This audit has demonstrated a direct referral pathway for suitable patients with groin hernia straight to pre-operative assessment can help deliver cost effective and efficient care. This has the potential to reduce waiting times and help re-allocate clinic for patients with complex needs.

0990: AN AUDIT OF THE MANAGEMENT OF PATIENTS WITH ACUTE PANCREATITIS AT AN EAST LONDON DGH

Amrita Banerjee, Sundeep Govind*, Faisal Mihaimeed, Amit Sinha. *Newham University Hospital, Barts Health NHS Trust, London, UK.*

Introduction: To audit the management of patients with acute pancreatitis, at a busy east London DGH, against the national standards of practice in the British Society of Gastroenterology guidelines.

Methods: A retrospective audit of 70 consecutive patients with acute pancreatitis was undertaken. Standards audited were correct diagnosis and severity stratification within 48hrs, aetiology determined in more than 80%, definitive management of gallstone pancreatitis within 2 weeks, overall mortality below 10 per cent and correct documentation of fluid balance status.

Results: The audit showed that severity stratification was documented in 41% of patients, while definitive management of gallstone pancreatitis within 2 weeks was undertaken in only 17% of patients. Correct fluid balance was documented in 27% of patients. Other standards were in keeping with the national guidelines. A clerking proforma was developed, distributed and an education programme undertaken. The audit was repeated after 6 months.

Conclusions: Improvement was shown in severity stratification (54% vs 41%) and correct fluid balance documentation (92% vs 27%). Delay to management of gallstone pancreatitis is a trust wide concern, which is being reviewed imminently. The clerking proforma is currently used within the surgical department, while implementation of an electronic proforma in A&E, is currently being considered.

1211: COMPARING SURROGATE MARKERS OF SURGICAL SITE INFECTION BETWEEN TWO DIFFERENT ANTIBIOTIC PROPHYLAXIS REGIMES IN TOTAL JOINT REPLACEMENT PATIENTS: A PROSPECTIVE STUDY

Punit Makwana, Satish Babu*. *William Harvey Hospital, East Kent NHS Trust, Ashford, Kent, UK.*

Introduction: Antibiotic prophylaxis decreases surgical site infection (SSI) after total joint replacement (TJR) (relative risk reduction up to 81%). The ideal antibiotic(s) are internationally debated with choice dependant on surgeon, cost and availability. We aimed to study surrogate markers of SSI in patients receiving Teicoplanin and Gentamicin and compare this to a previous study of Cefuroxime efficacy.

Methods: Patients admitted for TJR between 20/12/11 and 15/3/12 at William Harvey Hospital were given standardised questionnaires to complete 30 days postoperatively. Wound healing duration, postoperative antibiotic use and wound microbiology were assessed. We compared our results to the previous study (n=147).

Results: 71% of participants responded (n=149). 53% reported wound healing in <14 days (46% in previous study), 37% recorded 15–21 days (38% before) and 3% of wounds had not healed at 30 days (4% previously). 0.09% of subjects received postoperative antibiotics vs. 0.02% formerly. Both studies yielded 0 positive wound cultures.

Conclusion: We found no clinically significant difference in wound healing, postoperative antibiotic prescription and positive microbiology between regimes. We postulate Teicoplanin and Gentamicin is not superior to Cefuroxime. However the incidence of SSI after TJR is low. Therefore large-scale trials are required to evaluate statistically significant differences between antibiotics.

1309: OPERATION NOTES AUDIT CYCLE: ASSESSMENT OF COMPLIANCE WITH RCS GUIDELINES AT SOUTHPORT DGH

Abhishek Kalia, Andrew McAvoey*, Richard Steven, Frank Mason, David Jones. *Southport DGH, Southport, UK.*

Introduction: The culture of medical litigation in the UK is ever increasing. Good documentation of operation notes is therefore highly important. Furthermore, accurate documentation helps to maintain patient safety. The Royal College of Surgeons (RCS) has set out guidelines on what should be documented in operation notes. We aimed to assess compliance with these guidelines at Southport DGH, implement change to improve standards and then re-audit current practice.

Methods: In the initial audit, 100 operation notes were prospectively analysed by a single observer. The standards were the 14 points in the RCS guidelines. Changes were made to improve current practice including delivering a lecture on current practice, education of surgeons and installation of reminder notices of the guidelines in theatres. Practice was re-audited 1 year later.

Results: All 14 standards were met in 2% (1%) of operation notes. Greater than 90% compliance was achieved in 9 standards (10). Compliance with documentation of signature was 80% (67%); tissue samples obtained 97% (83%); time 35% (41%); elective or emergency 4% (7%).

Conclusions: Improvements were made in documentation of signatures and tissue samples obtained. Time and whether a procedure is elective or emergency are poorly documented. Overall compliance with RCS guidelines remains poor.

1323: DOES A WARD ROUND CHECKLIST IMPROVE DOCUMENTATION AND PATIENT CARE?

Sparsh Prasher*, Sheneen Meghji, Nitesh Patel. *Whipps Cross University Hospital, London, London, UK.*

Introduction: To assess the current quality of documentation of post-take ward rounds after the introduction of the ward round checklist.

Method: A retrospective audit of 50 patients from November 2013. Data was collected from post-take ward round case notes, drug charts, operation notes and the checklist and compared to the first cycle audit undertaken in September 2013.

Results: In 100% of patients a ward round leader was identified on a standard history sheet with the date and time recorded. A named consultant was recorded in 11% of the first cycle to 96% currently. Blood results recording improved from 9% to 88%. VTE prophylaxis improved from 4% to 100%. Review of antibiotics, analgesia and nutrition improved from 50% to 100%. Documentation of the patients progress and examination improved from 85% to 100%. Average patient stay reduced from 3 days to 2 days (p=0.048)

Conclusions: On a busy surgical ward round it is easy to miss, or fail to document certain aspects of patient-care. This checklist has shown significant improvements in documentation which has translated into enhanced patient-care and reduced inpatient stay.

1339: ARE PATIENTS REALLY ATTENDING THE EMERGENCY DEPARTMENT BECAUSE THEY CAN'T GET APPOINTMENTS WITH THEIR GP? A SERVICE REVIEW AT THE ROYAL LIVERPOOL UNIVERSITY HOSPITAL

Elizabeth Kane*, Ryan Robinson, Alison Waghorn. *Royal Liverpool University Hospital, Liverpool, Merseyside, UK.*

Introduction: High volumes of attendances at emergency departments are a strain on current services. This review aimed to determine the reasons that patients are attending the emergency department (ED) rather than the GP.

Methods: Patients attending the ED over 3 days in October 2013 were interviewed at triage using a standardised questionnaire.

Results: 302 patients were interviewed; 122 of these presented following an injury. 14.2% of patients were admitted. 40.3% of patients had seen a doctor about the presenting problem; 37% were awaiting relevant investigations or outpatient appointments. 62.9% of patients didn't think their GP could help, and even if they could have had an appointment with their GP, 78.8% would still have attended the ED. 55.9% felt the hospital was the best place to be seen, 15.2% named a specialist, while 7% thought the GP. Reasons for differences in opinions included convenience, lack of confidence in the GP, 'cutting out the middle man', and desiring investigations.

Conclusions: Reasons for not wanting to see a GP were broad, deterring ease of classification. This review identifies that poor relationships in the community, lack of communication and understanding are key areas requiring intervention. Patients feel dissatisfied with care provision in the community.